Supreme Court, U.S.
FILED

081533 MAR 9 - 2009

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No. (1)

In The

Supreme Court of the United States

DANA LYNN MEHEN,

Petitioner,

vs.

DELTA AIRLINES, INC., et al.,

Respondents.

On Petition For A Writ Of Certiorari To The Ninth Circuit Court Of Appeals

PETITION FOR A WRIT OF CERTIORARI

DANA LYNN MEHEN
Pro Se
2968 N. Webster Rd.
Tucson, Arizona 85750
(520) 290-9067

QUESTIONS PRESENTED

The Plan is a dual-role ERISA plan fiduciary, which means that it both decides whether beneficiaries are eligible for benefits and pays any benefits it grants out of its own pocket. The Sixth Circuit Court of Appeals found the Long Term Disability Plan's denial of an employee's disability claim arbitrary and capricious in multiple respects. The questions presented are:

1. WHETHER THE COURT OF APPEALS ERRED IN CONCLUDING THAT DELTA'S DUAL-ROLE STATUS IS NOT A CONFLICT OF INTEREST OR SHOULD THIS COURT CONSIDER REVIEWING DELTA'S BENEFIT DENIAL.

2. IF A DUAL-ROLE INSURER IS DEEMED TO BE OPERATING UNDER A CONFLICT OF INTEREST, USING TAINTED EVIDENCE AND OTHER ERISA PROCEDURAL VIOLATIONS, THEN HOW SHOULD THAT CONFLICT BE TAKEN IN TO ACCOUNT IN JUDICIAL REVIEW OF A DISCRETIONARY BENEFIT DECISION AND WHAT PENALTIES MIGHT APPLY?

3. DOES AN AMERICAN CORPORATION/ EMPLOYER HAVE THE RIGHT TO THREATEN AND HARASS AN EMPLOYEE AND FAMILY MEMBERS SIMPLY BECAUSE THE EMPLOYEE IS PURSUING JUSTICE THROUGH THE COURT SYSTEM, AND IF NOT, THEN WHAT PENALTIES SHOULD APPLY?

PARTIES TO THE PROCEEDINGS

The parties to the proceedings are the Respondents-Defendants: Delta Airlines, Inc ; Delta Family-Care Disability and Survivorship Plan; Delta's self-insured United Healthcare insurance; Delta Administrators: Mr. Mullins, Ms. Wibbens, Mr. Piper, Mr. Young, Ms. Frazier, Ms. Hord, Cobra Administrator, Mr. Heilmann; Delta Attorney: Mr. King; Delta Company Doctors, Salam Alkasspooles, M.D., James O'Brien, M.D., Delta Private Investigator, DDI Company; Mr. Pat Higgins and Petitioner Dana Lynn Mehen.

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PETITION FOR A WRIT OF CERTIORARI

The Petitioner, DANA MEHEN, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit, entered in *Dana Mehen v. Delta Airlines, Inc. et al.*, No. 06-16388 Order October, 24, 2008, Panel Re-hearing December 11, 2008.

OPINION BELOW

The decision of the Ninth Circuit is reported at *Mehen v. Delta Airlines, Inc., et al.*, No. 06-16388 (9th Cir. 2008). U.S. District Court of Arizona No. CV-02-00595-CKJ.

JURISDICTION

This petition seeks review of the judgment entered by the United States Court of Appeals for the Ninth Circuit, the Panel Rehearing Order denied December 11, 2008 in the matter of *Mehen v. Delta Airlines, Inc., et al.* This Court has jurisdiction over this matter pursuant to 29 U.S.C. § 1132. Delta Airlines, Inc., et al., has an ERISA employee benefit plan as defined by 29 U.S.C. § 1002/1003. The jurisdiction of this Court to review the judgment of the United States

Court of Appeals for the Ninth Circuit is invoked under the Title 28, United States Code § 1254(1).

STATUTES AND REGULATIONS INVOLVED

28 U.S.C. § 455

> (b) He shall disqualify himself in the following circumstances (4) He knows that he, he individually or as a fiduciary, or his spouse or minor child residing in his household, has a financial interest in the proceeding or any other interest that could be substantially affected by the outcome of the proceeding.

29 U.S.C. § 1132 Civil Enforcement

> Persons empowered to bring civil action. A civil action may be brought (1) by a participant or beneficiary.(A) for the relief provided for in subsection (c) or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan or to clarify his rights to the future benefits under the terms of the plan. As part of reform of employee benefits law, Congress enacted ERISA and placed emphasis on employer's or other plan sponsor's obligations to provide information about the employee benefits. One aspect of this is the duty of a plan administrator to respond to written requests for information. ERISA 502(c), 29 U.S.C. § 1132(c) provides for penalties for an administrator's refusal to supply required

information. Under that section of ERISA, (1) Any administrator . . . [who fails to provide certain information] [1] . . . (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 [2] a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

29 U.S.C. § 1104 Fiduciary Duties

(a)(1) Subject to Sections 1103(c)(d) and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the participants and beneficiaries and

(A) for the exclusive purpose of: (i) Providing benefits to participants and their beneficiaries and (ii) defraying reasonable expenses of administrating the plan.

29 U.S.C. § 1108(1)(c)(3)

> (1) Protective of the rights of the participants or beneficiaries of such plan, (c)(3) Serving as fiduciary in addition to being an officer, employee, agent or other representative of a party of interest.

489 U.S. at 101, 102, 113, 115

> De novo is the appropriate standard of review for denial of benefits. Under Arbitrary and Capricious standard, a district court will uphold a plan administrator's interpretation of a plan if it is reasonable, unless the plan administrators decision was without reason, unsupported by substantial evidence, or erroneous as a matter of law.
>
> A benefit plan gives discretion to an administrator or fiduciary who operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion, thus the default Standard of Review is de novo Standard of Review.

C.F.R. § 1601.01(e)

> The employer can be held liable for harassment if the employer knew of the harassment and failed to stop harassment.

ADA 1990

> Americans with Disabilities Act of 1990, Prohibits private employers, state, local government, government agencies, and labor

unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions and privileges of employment.

COBRA

Consolidated Omnibus Budget Reconciliation Act gives workers and families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as, voluntary or involuntary job loss, reduction of hours worked, transition between jobs, death, divorce and other life events.

ERISA

29 U.S.C. § 1001, Employment Retirement Income Security Act of 1974, Pub. L. 93-406, 88 Stat. 829 enacted September 2, 1974, is an American Federal Statue that established minimum standard for pension plans in private industry and provides for extensive rules of the Federal Income Tax effects of transactions associated with employee benefit plans. ERISA was enacted to protect the interests of the plan participants or their beneficiaries by requiring the disclosure to them of financial and other information concerning the plan; by establishing the standard of conduct for the plan fiduciary; and providing for appropriate remedies and access to the federal courts.

HIPPA

> Health Insurance Portability and Accountability Pub. 104-191 was enacted August 21, 1996. HIPPA amended ERISA to provide for improved portability and continuity of Health Insurance Coverage connected with employment, among other things.

H.R. 1592

> Mathew Shepard Act Local Law Enforcement Hate Crime Prevention Act 2007 (1) the term "crime of violence" has meaning given that term in Sec. 16, Title 18, U.S.C. (2) The term "hate crime" has the meaning given such term in Sec. 280003(a) of the Violent Crime Control and Law Enforcement Act of 1999(c) Is motivated by prejudice based on the actual or perceived race, color, religion, national origin, gender, sexual orientation, gender identity or disability of the victim or is a violation of the State, Local, Tribal, hate crime laws.

STATEMENT OF THE CASE

With all due respect for the Court, I, Dana Mehen respectfully request a petition for Certiorari, because the Ninth Circuit Appeals Court ruling in my case is in conflict with the new current ruling in Supreme Court case *Glenn v. Metro. Life Ins. Co.*, Supreme Court No. 06-923 (June 19, 2008). Also, to be considered is the Mathew Shepard Act H.R. 1592

2007 new information which encompasses the harassment directed toward a disabled person a hate crime. I ask for all protections afforded by the Americans with Disabilities Act laws. I respectfully ask for reconsideration with this Writ of Certiorari. The issues presented for consideration are a case of an ERISA appeal, of denied benefits, also it is a question of whether an American corporation has the right to harass its workers. Did my former employer have the right to harass, stalk and implicitly threaten myself and family because I became disabled as a result of my employment with the respondent? I feel that they did not have this right. It would appear that the District and Appeals Courts have not addressed the "dual-role" conflict of interest, abuse of discretion and breach of fiduciary duty or considered the Social Security Administration rating of disability that Mehen has continually held since January 1996 and the continual disabled opinion of my treating doctor, a toxicologist and occupational medicine expert in this particular field. The Plan administrator's opposite decision after Mehen's SSA disability rating is to now rule that Mehen is not disabled, in order to terminate Mehen's benefits, with the help of the company doctors that respondents hired to write "mischaracterizations of the medical record", *Buffonge v. Prudential Ins. Co. of America*, 426 F.3d 20, 31, n.15 (1st Cir. 2005) and completely ignoring Mehen's disability status with SSA or the ERISA and COBRA statutory violations, which is contrary to ERISA laws and requirements for "full and Fair review". In which a *de novo* standard of review

should have applied. Nor did the courts address the harassment campaign that has been directed at our family because I choose to pursue my rights under the laws of the United States of America, as an American citizen. False surveillance video was used to terminate Mehen's benefits. With the recent ruling of the case *Glenn v. Metropolitan Life Insurance Company*, Supreme Court, No. 06-923 (June 19, 2008), I respectfully ask the Court to issue the Writ because of the similar issues and new rulings presented in *Glenn v. Metropolitan Life Insurance Company*. I pray that the Court will provide justice, we have endured a severe hardship without medical benefits and as family have risked our lives to seek justice in this matter, believing in the American judicial system.

Petitioner Mehen was a loyal and dedicated employee of the defendants with an exceptional administrative record. During the course of this employment I became permanently disabled. I suffer from chemical toxicity non-pharmacological. Recently being labeled "Aero Toxic Disease" because of the increased numbers of crewmembers falling ill with this same disease, exposure to the toxic fumes onboard the aircraft. Reference www.welcomeaboard toxicairlines.com. My condition amounts to a chemically induced version of AIDS. I have no immune system. This diagnosis is not my own. I did not suddenly decide to become disabled as the defendants would like you to believe to remove their own culpability in this matter. I have been in the care of a respected and licensed toxicologist specialist in the

field of occupational medicine, for the past twelve years, Michael R. Gray, MD. There has never been any conflict with respect to my diagnosis. As part of the LTD program I was forced to visit physicians not of my own choosing, company doctors that were paid for by the defendants. Any and all reports by these physicians paid for by the defendants must be viewed as suspect, especially the changed medical report by Dr. Alkasspooles, MD. My own doctor has never wavered on my disability diagnosis. Mehen was required by the Delta Plan administrators to apply for SSA benefits in July 1995 and was awarded in January 1996. Mehen has the Social Security Administration disability rating since January 1996 and all SSA reviews since that time has labeled Mehen as disabled. Mehen has remained "continuously disabled within the meaning of the Plan language" not eligible for any gainful employment. The Plan was notified concerning my SSA award by U.S. Postal certified mail. The certified mail record was entered into evidence. I signed all releases for the Plan administrators to access all SSA records and all medical information. In addition, I cooperated with any and all Plan requests.

Because of my disabled condition I was targeted by my employer for dismissal. The medical benefits that I had earned through the course of my twenty year employment were effectively stopped September 1, 2000. Although Mehen appealed, all administrative remedies were exhausted and denied. My medical bills went unpaid, my credit was ruined, I was dismissed

from the program along with my family members. My minor daughter was struggling with a kidney disease first diagnosed in 1995. In my time of need the benefits that I had worked so hard for were denied me.

I was dismissed from the program because the respondents on June 29, 1999 surveyed my husband and two minor children claiming that the elder child (15 yr. old) was me. While employment law dictates that it is acceptable to use surveillance of an employee in a public place, I was NOT in the surveillance video. The law does not provide for the harassment of family members in this quest and the harassment remains ongoing to date because Mehen has pursued her rights in court. June 13, 2003, we caught the man harassing our family at night, he crashed into our gate and fence; it was the same man that delivered legal papers by day for the respondents' local attorneys Lewis/Roca, One South Church Ave., Tucson, Arizona 85701. This man along with other operatives are still harassing our family although we have made numerous complaints to the Pima County Sheriff's dept. and the FBI, this harassment is ongoing. We have experienced harassing telephone calls all night, break-ins to our home and autos, smashed windshields, dented car fenders, continually followed, run off the road, prowling at our home, acts of vandalism at our home, stolen mail, smashed mailbox, nails in the driveway causing flat tires, and recent incident I was run off the road on 1/17/2009. Furthermore, the harassment is also directed at my 81 yr. old widowed Mother, Alice

Mehen and the others who signed the witness affidavits to enter into District Court, have all experienced some form of harassment and threats.

After being ousted from the long term disability benefits program I was forced to enroll in COBRA. My payments were rejected, my checks were sent back. The U.S. Department of Labor Ms. Gloria Polk forced the Respondents to reinstate Mehen to the COBRA Plan and still the medical bills remained unpaid. Ms. Polk referred Mehen to HIPPA (national health insurance coordinator) where it was determined that Mehen's employment was listed by Delta Airlines as "terminated". Mehen went to the EEOC, was issued the "right to suit" with the basis being discriminatory for denial of benefits and termination of employment. Delta quickly reversed the termination attempt. Upon receiving medical services ordered by my doctors, the institutions were told repeatedly "Mehen has no insurance coverage" although all payments to COBRA were paid and current. After a piecemeal enrollment in the program for approximately one year I applied and was qualified to receive an extension of coverage because I am a person with a recognized disability according to the Social Security Administration. My family and myself were unlawfully denied the COBRA extension. I did notify the Plan about my disability as required by certified mail. A copy of the certified mail record was submitted as evidence.

Petitioner Dana Mehen was employed by Delta Airlines Inc. for approximately twenty years before

she became permanently disabled as a result of her employment with Delta Airlines where she was exposed to toxic chemicals onboard the aircraft, jet exhaust, jet fuel, smoke fume events, oil/lubricants, de-icing fluid, hydraulic fluid, DDT pesticides and other toxic chemicals all a part of regular commercial airline operations.

Mehen has at all times since going on medical leave from Delta Airlines been totally disabled. She has continually been affirmed 100% disabled by the Social Security Administration. Mehen was an excellent employee with many letters of commendation from Delta Airlines, the public and fellow co-workers.

As a disabled employee Mehen applied for benefits through the Delta Long Term Disability Plan which she received. Although Mehen has remained fully disabled at all times under the Long Term Benefits Program (hereafter the Plan) Mehen was subject to harassment and the constant fear that her desperately needed medical benefits would be terminated. The process to retain medical benefits under this program can be viewed as nothing but arbitrary and capricious. The Plan required Mehen to attend hostile doctor's visits paid for by her employer. The opinions of these doctors could be used to usurp the formal and repeated diagnosis of Mehen's long term physician. In sum the opinion of a doctor paid for by the Plan, a visit that in some cases involved no examination, and the opinion of a doctor who was not a specialist in the area of Mehen's disability could override the findings of her long term care provider

who is a noted specialist in the field of toxicology. Mehen was disabled by toxic chemical exposures on the aircraft which resulted in systematic and total immune failure. Mehen's condition is similar to patients suffering the effects of the AIDS/HIV virus with no available cure.

These practices, by the Plan to systematically and inexplicably ignore critical evidence, reverse positions, and reject the consistent opinion of an examining Physician in favor of consultants who reviewed a cold paper record speaks to the failure of fiduciary duty that exist within these dual-role trusts.

The Supreme Court's direction in *Bruch v. Firestone Tire & Rubber*, 828 F.2d 134 (3d Cir. 1987), *aff'd in part, rev'd in part on other grounds*, 489 U.S. 101 (1989), that such a dual role "conflict *must* be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" (quoting RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959) ("SECOND RESTATEMENT") (emphasis added)). The rulings in Mehen's case so far have neglected to follow this direction.

Mehen becomes totally disabled

After years of medical treatment for a plethora of symptoms: Immune failure, Toxic Encephalathapy, Neurological damage, Brain Lesions (myelin in blood) MS, Lupus, Chronic Fatigue, Brain Injury, severe headaches brought on by brain swelling, mental confusion, memory trouble, vision changes, photophobia, Fibromyalgia, Large/Small airways disease,

Asthma, viruses brought on by failed immune Eppstein-barr, CMV, #6, open sores that never heal due to viruses, ear infections and abnormalities, incontinence, loss of bowel control, Chronic Upper Respiratory Infections, lymph swelling and continual infections, testing for lymphoma, abdominal tumors, Supplemental Oxygen needed, loss of use of left side limbs indicating possible stroke, muscle weakness, Hypertension uncontrollable, Pain on a daily basis, Depression, and recently severe diabetes. No such health problems in Mehen's family history. Mehen was healthy and athletic before this illness struck. Mehen has been continuously disabled since 1994. Mehen is unable to leave her bed for months after using all of her sick time and short term disability benefits. Mehen goes on to Long Term Disability December 1994. At all times Mehen was eligible to be a participant in the Plan. The only stipulation of the Delta Family-Care Plan was that Mehen remain continuously disabled which she has done, is disabled to this date, which is documented by her treating physicians and maintains the Federal Social Security Disability rating.

Delta forces Mehen to apply for Social Security benefits

July 1995 the Plan administrators tell Mehen she will not receive any more Plan benefits until she applies for SSA. She was awarded Social Security benefits on the first evaluation by SSA doctors.

Mehen is awarded Social Security benefits

January 1996 Mehen has retained this federal rating from this time forward. Mehen is a "Qualified" individual as defined by the Social Security Administration and the ADA, whose life has been dramatically affected in more than four major areas of life such as walking, breathing, sleeping and standing. She is 100% disabled with a poor prognosis. September 1, 2000 received a letter terminating her benefits. She was no longer entitled to benefits from the Delta Family-Care Plan as she did not meet the stringent definition of the Plan which states "that the employee must remain continuously disabled". After forcing Mehen to pursue her Social Security benefits and ceding that she is totally disabled by continuing her benefits following the Social Security decision, the Plan then began to require Mehen to attend multiple hostile doctor's visits in attempt to reverse the SSA and treating doctor's diagnosis of disabled.

Termination of Benefits

After visiting more than 24 doctors there were only two hostile doctors who doubted Mehen's condition in any regard. Salam Alkaspooles, MD, gave an initial disabled report (June 1999) then changed the report one year later to say not disabled: James O'Brien, MD. Both reports lead to the termination of Mehen's benefits. Both company doctors paid for by the Delta Plan.

James O'Brien MD is a psychiatrist for the Medical Consultants Network. He made the determination that Mehen was *physically* able to go back to work. "Claimant (Mehen) had a history of missing work for dubious reasons for instance Maternity Leave".

Salam Alkasspooles, MD wrote a report in June 1999 after examining Mehen, stating that in his professional opinion Mehen was disabled and would need to be re-evaluated in six months to see if her disabled condition might change. In July 2000 more than a year and without any re-examination he wrote the addendum stating "she can work". Common sense and personal integrity would not allow a physician to make a determination about a patient without examining the patient in person. Along with the FALSE surveillance video of June 29, 1999 of Mehen's husband and two minor daughters, respondents terminated Mehen's benefits.

Delta Persists in Denial, Ignoring Key Medical Information and the SSA Ruling

The Plan held the decisions of these two doctors above the prevailing consensus, the decision of the Social Security Administration and the diagnosis of Mehen's treating physician a specialist in the field of toxicology, occupational medicine and her primary care physician. After exhausting all administrative remedies, Mehen files suit in Federal Court for benefits owed to her under 29 U.S.C. § 1132(a)(1)(B).

REASONS FOR GRANTING THE PETITION

I. A DUAL-ROLE INSURER OPERATES UNDER A CONFLICT OF INTEREST THAT A COURT SHOULD CONSIDER IN REVIEWING BENEFIT DENIALS.

One cannot depend upon the dual-fiduciary to be self regulating. Businesses will time and time again seek to enhance profit. This creates an inherent conflict of interest that cannot be surmounted to create a true fiduciary. *Metropolitan Life Ins. Co. v. Glenn*, Supreme Ct., 06-923, June 19, 2008. Other examples, 28 U.S.C. § 455(b)(4), Major league baseball rules 21(d), Delta LTD Plan, "is exercising discretion over a situation for which it incurs direct, immediate expense as a result of benefit determinations favorable to the Plan participants." *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1561 (11th Cir. 1990) (quoting *De Nobel v. Vitro Corp.*, 885 F.2d 1180, 1191 (4th Cir. 1989). That is the classic definition of an "economic conflict of interest by a fiduciary," under trust law and common parlance. See John H. Langbein, Trust Law as Regulatory Law: *The Unum/Provident Scandal and Judicial Review of benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315 (2007) (documenting the scandal), *Bennett v. Unum Life Ins. Co. of Am.*, 321 F. Supp. 2d 925, 933 (E.D. Tenn. 2004), *Radford Trust v. First Unum Life Ins. Co. of Am.*, 321 F. Supp. 2d 226, 247 & n.20 (D. Mass. 2004), *rev'd in part on other grounds*, 491 F.3d 21 (1st Cir. 2007). In the *MetLife* case regulators concluded that the conflict of interest could

have tainted as many as 200,000 claim denials. As the California Insurance Commissioner observed "this not just an Unum Provident problem, it's an insurance industry one". See Peter Gosselin *The New Deal: The Safety Net She Believed In Was Pulled Away When She Fell*, L.A. Times, August 21, 2005. The National Asso. of Insurance Commissioners agrees. See NAIC Br., Prof. Langbein, 101 Nw. U.L. Rev. at 1321-22 & n.41, GEORGE BOGERT ET AL., THE LAW OF TRUSTS & TRUSTEES 543 (rev. 2d ed. 1993), AUSTIN SCOTT & WILLIAM FRATCHER, THE LAW OF TRUSTS 107.1 (4th ed. 2001). Other cases, *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997). As this Court has emphasized, a "benefit determination under ERISA. . . . is generally a fiduciary act," *Aetna Health Inc. v. Davila*, 542 U.S. 200, 218 (2004); *Saffle v. Sierra Pacific Power Co.*, 85 F.3d 455 (9th Cir. 1996); *Salley v. E.I. Dupont de Nemours & Co.*, 966 F.2d 1011, 101.

A. As This Court Has Held, Congress Did Not Prescribe How to Review the Decisions of a Dual-Role Insurer, but Trust Law Provides the Answer.

I. Everyone agrees the most explicit statement Congress made about dual-role fiduciaries is this: ERISA should not be construed "to *prohibit* any fiduciary from . . . serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest." 29 U.S.C. § 1108(1)(c)(3) (emphasis added). As The Plan acknowledges, this

provision *"authorizes"* the dual role. All that means is that the conflict is *not illegal.* Pet'r 21, 22. Congress did not, however, say anything about how courts should defer to an insurer operating under such a conflict. In fact, in *Firestone*, this Court held that ERISA says nothing at all about standards of review for benefit denials. There, this Court adopted *de novo* review as the default standard in ERISA cases. 489 U.S. at 115. The *de novo* standard of review needs to be applied in this matter. ERISA was enacted "to promote the interests of employee benefit plans and to protect contractually defined benefits." *Shaw v. Delta Airlines Inc.*, 463 U.S. 85, 90 (1983), *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985). In the pre-ERISA world, employees had the right to bring state-law contract claims for the denial of promised benefits and those claims would be subject to *de novo* review and any contractual ambiguity would have resolved against the insurer. G. COUCH, R. ANDERSON, & M. RHODES, COUCH ON INS. 2D 15:83, at 399 n.4 (rev. ed. 1984) (citing cases from the District of Columbia and 47 states, with no contrary authority). These protections shielded the employee from any possibility that the insurer's profit motive would affect any decision. See trust cases: *Armington v. Meyer*, 236 A.2d 450 (R.I. 1967), *White Mountain Apache Tribe v. United States*, 249 F.3d 1364, 1379 (Fed. Cir. 2001) (the Court must be careful in scrutinizing actions of a conflicted trustee), *aff'd* 537 U.S. 465 (2003); *Peabody's Will*, 96 N.Y.S. 2d 556, 561 (Sup. Ct. 1950) (when a trustee operates under an authorized conflict, "his conduct in

administering the trust will be more closely scrutinized"), *aff'd* 98 N.Y.S.2d 614 (App. Div. 1950), *Heller*, 849 N.E.2d 262-66 (N.Y. 2006) ("scrutinized by the courts with special care"); *Messler v. Holly*, 318 So.2d 530, 533 (Fla. App. 1975) (conflicted trustee's decision becomes particularly vulnerable to a challenge by other beneficiaries); *In the Estate of McCart*, 847 P.2d 184, 185-187 (Col. Ct. App.1992) (applying close scrutiny to conclude that trustee-beneficiary abused discretion), *In Buchar's Estate*, 74 A. 237, 238 (Pa. 1909) (same); *Garvey v. Garvey*, 22 N.E. 889, 890 (Mass. 1889) (same); *In the Estate of Gilliland*, 140 Cal. Rptr. 795, 802 (Ct. App. 1977).

B. This Court Correctly Concluded That, Under Trust Law, a Fiduciary's Authorized Conflict of Interest Must Be Weighed as a Factor in Reviewing the Fiduciary's Decision.

I. This case presents an obvious conflict of interest. As a dual-role insurer the Plan has a financial stake in every claim for benefits that is submitted under the plan. There is nothing "potential" about the Plan's financial interest. Every time the Plan concludes that a claimant is entitled to benefits under the plan, it must reach into its own pocket and pay those benefits. Conversely, every time the Plan denies a claim, it saves the money it would have paid the employee – as it did with Mehen. *Metropolitan Life Ins. Co. v. Glenn*, Supreme Ct., 06-923, June 19, 2008. Nevertheless, the Plan insists that a court is forbidden

even to consider the conflict in reviewing a benefit denial under 29 U.S.C. § 1132(a)(1)(B). Most circuits disagree with The Plan's position. That is because The Plan's position finds no support in ERISA or its underlying policies, in this Court's precedent, or in trust law. ERISA does not prohibit a court from weighing a dual-role conflict when reviewing a benefit denial claim. All ERISA says is that it will not "*prohibit* any fiduciary" from serving a dual role. 29 U.S.C. § 1108(1)(c)(3) (emphasis added). As this Court held in *Firestone*, Congress said nothing about how courts should scrutinize a benefit denial. Rather, ERISA imports trust law to define the standard of review. Trust law says exactly what this Court observed in *Firestone*: When a trustee operates under a conflict of interest, "that conflict *must* be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting SECOND RESTATEMENT § 187, cmt. d (emphasis added)).

II. Review of the Decisions of a Dual-Role Insurer Must Require Careful Scrutiny

In fact, trust law speaks directly to the questions presented. The most explicit statement in the most current and definitive distillation of trust law describes how courts should account for a bare conflict: Whenever bare "conflict-of-interest situations exist" – i.e., even when there is no additional evidence that the conflict affected the fiduciary's decision – "the conduct of the trustee in the administration of the trust will be subject to *especially careful scrutiny*."

RESTATEMENT (THIRD) OF TRUSTS § 37, cmt. f(1) (2001), (2005) (emphasis added) ("THIRD RESTATEMENT"). ERISA's goals support the result dictated by trust law. The statutory goal that dominated the Court's opinion in *Firestone* was "to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." 489 U.S. at 113 (citations 14 and internal quotation marks omitted). As in *Firestone*, this concern supports careful scrutiny. *Firestone* held that the default rule in an ERISA case is *de novo*, because otherwise employees would have less protection than they had pre-ERISA. The same is true here. If a court must give a dual-role insurer utmost deference, without any consideration of the conflict, an employee who was the victim of an improperly motivated benefit denial would be much worse off than he would have been with a contract claim under ERISA. As is evident from the Restatements, treaties and trust cases quoted above, a dual role conflict is an actual conflict, because "the administrator has an interest (e.g., in profit or a better bottom line) that is adverse to the interests of the beneficiaries seeking payment." *Post v. Hartford Ins. Co.*, 501 F.3d 154, 163 (3rd Cir. 2007). Regardless of what the employer might consent to, the statue requires a fiduciary always to "discharge his duties with respect to a Plan solely in the interest of the beneficiaries for the exclusive purpose of providing benefits to the participants and their beneficiaries." 29 U.S.C. § 1104(a)(1)(A)(i). The Plan worries that diminished deference leads to higher

costs and more frivolous litigation. This Court considered and rejected those arguments when it chose *de novo* review as ERISA's default standard. The arguments are even less compelling in a dispute over standards for a conflicted fiduciary. In any event, the rule The Plan opposes has been in place for decades in most courts, and no such dire consequences have materialized. Equally meritless are The Plan's various other arguments against weighing the conflict. None of the supposed business realities apply. Similarly, arbitrary – and capricious review will not suffice to guard against an insurer's conscious or subconscious shading of benefit decisions. And state and federal administrative agencies do not, and are not expected to protect individual claimants. Congress prescribed complementary roles for *both* regulators and judges. While regulators provide *systematic* oversight, Congress gave judges the responsibility to review individual claims for benefits due – like this one – under § 1132(a)(1)(B), and to do so in a way that advances both ERISA's goal of protecting claimants' contract rights and its unswayable requirement that Plan fiduciaries act in the sole interest of beneficiaries. *Glenn v. Metropolitan Life Ins. Co.*, Supreme Ct. ruling #06-923, June 19, 2008. Furthermore in ERISA cases, most courts of appeals, echoing trust law, have held that a conflicted fiduciary's judgment will be scrutinized more closely, which means that "deference will be lessened." *Doe v. Group Hospitalization & Med. Services*, 3 F.3d 80, 86-87 (4th Cir. 1993). *Brigham v. Sun Life of Can.*, 317 F.3d 72, 81-86 (1st Cir. 2003). The lower courts need this Court's guidance

not just on the name of the standard but on how to apply it. "Reasonableness", in trust law, requires more than just some rational connection between a shred of evidence and the conclusion. *Copp v. Worcester County National Bank*, 199 N.E.2d 200, 202 (Mass. 1964).

A. Deference to a Dual-Role Insurer Should Decline As Scrutiny Exposes Additional Reasons That the Conflict May Have Affected the Insurer's Decision

At some point the suspicion of taint can be sufficiently strong that the reviewing court should give no deference to the conflicted insurer's decisions and apply *de novo* review. The presence of these factors would have justified diminishing deference far below the level of "careful scrutiny" and even all the way to zero . . . *de novo* review. In Mehen's case the Plan's interpretation "defied all common sense." *Dabertin v. HCR Manor Care, Inc.*, 373 F.3d 822, 828 (7th Cir. 2004). See Kathryn Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U.L. REV. 1083, 1155 (2001); *Stup v. Unum Life Ins. Co. of Am.*, 390 F.3d 301, 307 (4th Cir. 2004) (quoting *Ellis*, 126 F.3d at 233); *Wright v. Donnelly & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74 (1st Cir. 2005); *Van Boxel v. Journal Co. Employee's Pension Trust*, 836 F.2d 1048, 1052-53 (7th Cir. 1987); *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d at 789, 794, 797, 799-780 (9th

Cir. 1997). Under trust law the only reason a fiduciary enjoys any deference is that he is obligated to make decisions wholly in the interests of the beneficiary. See *Clement v. Larkey*, 863 S.W.2d 580, 581-82 (Ark. 1993); *Buchar's Estate*, 74 at 237. In determining whether to diminish deference, courts should be free to evaluate any evidence bearing on the conflict or the fiduciary's behavior. *Fought v. Unum Life Ins. Co. of America*, 379 F.3d 997 (10th Cir. 2004). The most common form of evidence that a conflicted fiduciary succumbed to the conflict is evidence about the process. . . . "how the administrator treated the particular claimant." This category includes various "irregularities" such as: "(1) reversal of position without additional medical evidence; (2) self-serving selectivity in the use and interpretation of physicians' reports; (3) disregarding staff recommendations that benefits be awarded," (4) "providing inconsistent reasons for denial"; (5) "failing adequately to investigate a claim"; (6) "failing to credit a claimant's reliable evidence," *Abatie*, 458 F.3d at 968; and (7) denying disability after advocating disability to the Social Security Administration, without explaining the difference, *Ladd v. ITT Corp.*, 148 F.3d 753, 755-56 (7th Cir. 1998). Mehen's case included most of the above statutory violations, irregularities and lack of compliance which provided ample evidence of a conflict of interest, any of these factors would have justified diminished deference far below the level of "careful scrutiny" . . . even all the way to zero, to *de novo* review. The lower courts failed to consider this ample evidence of a conflict of interest. Additionally,

other factors the courts of appeals have identified in this category are: (1) whether the administrator "uses an independent body to evaluate claims"; (2) "whether the insurance contract is fixed for a term of years or changes annually; (3) whether the fee paid by the company is modified if there are especially large outlays of capital by the insurer"; (4) whether the insurer has displayed "a parsimonious claims-granting history," *Abatie*, 458 F.3d at 968-69, *Unum Group Swings to Profit from Quarterly Loss*; *Claims Reassessment 'Substantially Completed'*, BEST WIRE (Nov. 1, 2006). The Ninth Circuit "sliding scale" approach was not used in my case, *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998).

B. As This Court Has Held A Claim Administrator Must Specifically Consider A Bare Determination Of The Social Security Administration Which Must Be Considered By An ERISA Administrator

The Plan never disagreed with the SSA determination, after requiring Mehen to apply for SSA benefits. That about-face action alone can be considered "arbitrary and capricious".

The Plan also failed to give any weight to Dr. Gray's reports, in which he clearly stated Mehen's total disability and stated "not eligible to engage in any gainful employment", made mischaracterizations of the medical report, ignoring medical evidence . . . "by itself, is arbitrary and capricious." Peter J. Wiedenbeck,

ERISA in the Courts 194 (2008). Savvy insurers will "cherry pick" and accentuate their best facts, while ignoring their worst facts with little explanation. *Schatz v. Mutual of Omaha Ins. Co.*, 220 F.3d 944 (8th Cir. 2000).

C. The New Case Law Standard Should Be Applied Invoking a *de novo* Standard Of Review Which Will Require An Alternate Conclusion

I respectfully ask the Court to apply the new case law standard to reiterate the decision and affirm that a conflict of interest must be weighed as a factor in this matter of *Mehen v. Delta Airlines, Inc., et al.*, as you found in *Glenn v. MetLife Ins. Co.*, 06-923 Super Ct. June 19, 2008.

In addition, the Respondent's Bankruptcy Court case has tried to wrongfully include ERISA issues which are not a part of the Debtor's estate further trying to escape responsibility and complicate these issues, I cite *Patterson v. Shumate*, No. 91-9131992, nor should any penalties paid by the Plan be a part of the Bankruptcy Court, as the Plan is not a part of the Debtor/Respondent's estate. The denial of benefits, mischaracterization of the medical records, lack of compliance, false surveillance DVD, failing to provide the false surveillance DVD, the many statutory violations and harassment campaign were done with malicious intent and must be penalized sending a clear message, that these actions will not be tolerated. The

$110.00 penalty must be levied against the respondents, levied and enforced to the maximum extent that the law allows. 29 U.S.C. § 1024(6)(4), Sec. 502(c)(a)(1)(A), *Castello v. Gamache*, 593, 361 (8th Cir. 1979), H.R. 1592 Mathew Shepard Act 2007, and all protections provided by the Americans with Disabilities Act. Also, 29 C.F.R. § 1604.01(e) states "that the employer can be held liable for harassment, if the employer knew of the harassment and failed to stop harassment", the eye witness accounts on the night of June 13, 2003 when the man delivering papers by day (for Respondent's local attorneys) was identified at night harassing our family at our house, it directly links the ongoing harassment to the respondents, Delta Airlines, Inc., et al. Also, in *Glenn v. Met. Life Ins. Co.*, 2007 U.S. Dist. Lexis 1421, at *12 (S.D. Ohio Jan. 8, 2007), the District Court found MetLife's "culpability . . . high" and ordered MetLife to pay Ms. Glenn's attorney's fees and costs.

CONCLUSION

I pray that the Court will grant the Writ of Certiorari to resolve the questions above. For these reasons, the judgment of the Court of Appeals should be vacated or reversed.

Respectfully submitted,

DANA LYNN MEHEN
Pro Se
2968 N. Webster Rd.
Tucson, Arizona 85750
(520) 290-9067

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DANA LYNN MEHEN, Plaintiff-Appellant, v. DELTA AIRLINES, INC.; DELTA FAMILY CARE MEDICAL PLAN; DELTA FAMILY CARE DISABILITY AND SURVIVORSHIP PLAN; ADMINISTRATIVE SUBCOMMITTEE; ADMINISTRATIVE COMMITTEE; LEO MULLINS; SHARON WIBBEN, Vice President of In-Flight; UNITED HEALTHCARE, for the Medical Plan-Sponsored by Delta Airlines; COBRA ADMINISTRATORS, ERISA BENEFITS; LEON PIPER, Vice President of Worldwide Benefits; CHRISTOPHER YOUNG, Long Term Disability Administrator; ANNETTE FRAZIER, Long Term Disability Administrator; BEVERLY HORD, Long Term Disability Secretary; ROBERT HEILMANN, COBRA	No. 06-16388 D.C. No. CV-02-00595-CKJ MEMORANDUM* (Filed Oct. 24, 2008)

* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

Department Supervisor; BRIAN KING, Administrative Secretary; JAMES O'BRIEN; DDI COMPANY; PAT HIGGINS,

Defendants-Appellees.

Appeal from the United States District Court
for the District of Arizona
Cindy K. Jorgenson, District Judge, Presiding

Submitted June 6, 2008**

Before: SKOPIL, FARRIS, and BEEZER, Circuit Judges.

Dana Mehen brought this ERISA action against her former employer and its long-term disability plans, challenging the termination of her disability benefits. She argues the district court erred by reviewing the termination decisions for an abuse of discretion rather than applying de novo review. We conclude the court applied the proper standard and accordingly we affirm.

The proper standard of review depends on the language of the plan. If the plan administrator is not empowered by the plan "to determine eligibility for benefits or to construe the terms of the plan," the court's review is de novo. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). "But if the plan

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** The panel unanimously finds this case suitable for decision without oral argument. *See* Fed. R.App. P. 34(a)(2).

does confer discretionary authority as a matter of contractual agreement, then the standard of review shifts to abuse of discretion." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 963 (9th Cir. 2006) (en banc) (italics in original).

The plan here provides for "the broadest discretionary authority permitted under law in the exercise of all of its functions, including, but not limited to, deciding questions of eligibility and interpretation." Such language clearly confers discretion on the plan administrator to make final benefit determinations. *See id.* (noting "similar plan wording – granting the power to interpret plan terms and to make final benefits determinations – confers discretion on the plan administrator").

Mehen nonetheless argues the plan administrator has an inherent conflict of interest in protecting profits and thus de novo review is appropriate. We have held, however, that the "[a]buse of discretion review applies to a discretion-granting plan even if the administrator has a conflict of interest." *Id.* at 965. Mehen also argues for de novo review based on her claims of "procedural violations." Even assuming there were such violations, "a procedural irregularity in processing an ERISA claim does not usually justify de novo review." *Id.* at 972. Rather, "[a] procedural irregularity, like a conflict of interest, is a matter to be weighed in deciding whether an administrator's decision was an abuse of discretion." *Id.*

Under an abuse of discretion standard, the plan administrator's decision may be set aside "only when it is arbitrary and capricious." *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan,* 370 F.3d 869, 875 (9th Cir. 2004). A decision is not arbitrary or capricious if "grounded on *any* reasonable basis." *Id.* (italics in original). Thus, "as long as the record demonstrates that there is a reasonable basis for concluding that the medical condition was not disabling, the decision cannot be characterized as arbitrary, and we must defer to the decision of the plan administrator." *Id.* at 879. Although there was conflicting medical evidence regarding Mehen's level of disability, we agree with the district court that the plan administrator's decision to terminate Mehen's disability benefits cannot be said to be arbitrary and capricious or an abuse of discretion.

There was also no abuse of discretion when the plan denied Mehen's request for an extension of her COBRA benefits. Mehen's "qualifying event" did not occur within the initial 18-month COBRA period and she did not notify the plan administrator within 60 days of the date of the event as required by the plan.

AFFIRMED.

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

Dana Lynn Mehen, Plaintiff, vs. Delta Airlines, Inc., et al., Defendants.	No. CV 02-00595 TUC CKJ **FINAL JUDGMENT**

WHEREAS, having considered the parties' written memoranda, evidence submitted, oral arguments and the applicable law:

(a) The Court granted by Order filed May 11, 2005, the Motion for Summary Judgment of the Administrative Committee of Delta Air Lines, Inc., the Administrative Subcommittee of Delta Air Lines, Inc., the Delta Family-Care Disability and Survivorship Plan and the Delta Family-Care Medical Plan (the "ERISA Defendants") on all claims brought against them by plaintiff;

(b) The Court, in the same Order, granted the Motion for Summary Judgment of Delta Air Lines, Inc. on all claims brought against it by plaintiff; and

(c) The Court, by Order dated May 12, 2006, dismissed with prejudice the ERISA Defendants counterclaim against plaintiff with prejudice,

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED:

1. That Delta's Motion for Summary Judgment be granted as to each and every claim brought against Delta by plaintiff, and that final judgment be entered herein in favor of Delta on plaintiff's claims;

2. That the ERISA Defendants' Motion for Summary Judgment be granted as to each and every claim brought against the ERISA Defendants by plaintiff, and that final judgment be entered herein in favor of the ERISA Defendants;

3. That judgment be entered in favor of Plaintiff and against the ERISA Defendants on the counter-claim brought by the ERISA Defendants against plaintiff; and

4. That the parties recover nothing from any of the other parties.

Dated this 15th day of June, 2006.

/s/ Cindy K. Jorgenson
Cindy K. Jorgenson
United States District Judge

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

Dana Lynn Mehen, Plaintiff, vs. Delta Airlines, Inc., et al., Defendants.	**JUDGMENT IN A CIVIL CASE** Case No. CV 02-00595 TUC CKJ (Filed May 18, 2006)

DECISION BY COURT. This action came under consideration before the Court. The issues have been considered and a decision has been rendered.

IT IS HEREBY ORDERED AND ADJUDGED that the ERISA Defendants' counterclaim is **DISMISSED WITH PREJUDICE.**

May 12, 2006
Date

RICHARD H. WEARE
CLERK

/s/ Jill Tarlton
By: Jill Tarlton
Deputy Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Dana Lynn Mehen, Plaintiff, vs. Delta Airlines, Inc., et al., Defendants.	No. CV 02-00595-TUC-CKJ **ORDER** (Filed May 11, 2006)

Pending before the Court is the ERISA Defendants' request to voluntarily dismiss the case (Doc. #202). As summary judgment has already been granted as to all of Plaintiff's claims, the ERISA Defendants' counterclaim is the only remaining claim in this case. As such, pursuant to FED.R.CIV.P. 41(a)(2), IT IS HEREBY ORDERED that the ERISA Defendants' counterclaim is **dismissed with prejudice**. IT IS FURTHER ORDERED that the **Clerk of the Court shall dismiss this case with prejudice, close the file in this matter, and enter judgment accordingly**. In light of this dismissal, the status conference scheduled for 5/12/06 is vacated.

DATED this 11th day of May, 2006.

/s/ Cindy K. Jorgenson
Cindy K. Jorgenson
United States District Judge

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DANA LYNN MEHEN, Plaintiff-Appellant, v. DELTA AIRLINES, INC.; et al., Defendants-Appellees,	No. 06-16388 D.C. No. CV-02-00595-CKJ District of Arizona, Tucson ORDER (Filed Dec. 11, 2008)

Before: SKOPIL, FARRIS, and BEEZER, Circuit Judges.

We construe Mehen's pro se request for rehearing to be both a petition for panel rehearing and a petition for rehearing en banc. The panel has voted unanimously to deny the petition for rehearing. The full court has been advised of the petition for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. *See* Fed. R. App. P. 35. Accordingly, the petition for rehearing is DENIED and the petition for rehearing en banc is DENIED.